Student Medical Certificate

Confidential Information

*Student Number: _____

A. To be completed by student:

I, _____ hereby authorize the physician named below to provide the following information to BCIT.

_____ _____

Signature Date

B. To be completed by physician:

I hereby certify that I provided medical services to _____, a student at BCIT. On the basis of the care provided, I am submitting the following information for use by BCIT in assessing what special consideration, if any, should be given to this student with respect to missed or affected classes, labs, assignments, tests or examinations.

1. Date(s) patient seen: _____

2. Is this an acute or chronic problem? _____

3. Date of onset of problem (or acute episode if problem is chronic): _____

4. Expected duration of the problem and treatment: _____

5. The immediate and/or ongoing impact of this problem and/or the treatment on the student's ability to meet academic commitments (such as attending classes, participating in labs and workplace practicums, safely operating equipment, completing assignments, preparing for and/or writing tests and examinations, completing courses, etc.) is as follows:

_____

_____

_____

_____

6. Diagnosis or nature of health problem: **(Not Required** unless for use by BCIT Accessibility Services) (Please do not complete this section unless the student has specifically requested you to do so.)

_____

_____

_____

Signature: _____

Name (Please print): _____

Date: _____

Office Address Stamp:

Please retain copy for the patient's chart
Note: Any cost for this certificate must be paid by the patient

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